

RENEWAL REHABILITATION

HYDE PARK CLINIC • 613 S. MAGNOLIA AVE., SUITE 2, TAMPA, FL 33606 • (813) 254-9475 • FAX (813) 251-0460
WESLEY CHAPEL CLINIC • 2008 ASHLEY OAKS CIRCLE • WESLEY CHAPEL, FL 33543 • (813) 907-0430 • FAX (813) 907-0963

www.renewalrehab.com

PHYSICAL THERAPY ORDERS

PATIENT NAME _____

DATE _____

DIAGNOSIS _____

D.O.I. _____

PRECAUTIONS/INSTRUCTIONS _____

D.O.S. _____

FREQUENCY _____ (times per week)

DURATION _____ (weeks)

PHYSICAL THERAPY

- Evaluate and Treat
- Evaluate Only
- KLT 2000 Knee Laxity Test
- Orthotic Eval/Fitting



GOALS OF THERAPY

- Decrease Pain
- Decrease Inflammation
- Improve ROM
- Improve Strength
- Improve Conditioning
- Improve Function
- Patient Education
- Other

MODALITIES

- Moist Heat
- Cold Packs/Cryotherapy
- Ultrasound
- Phonophoresis
- Iontophoresis
- Electrical Stimulation
- Cervical Traction
- Pelvic Traction

THERAPEUTIC PROCEDURES

- PROM
- AROM
- AAROM
- PRE'S
- Isometric
- Flexibility Training
- Manual Mobilization
- Therapeutic Massage
- Proprioceptive Training
- Physical Reconditioning
- Plyometrics

EDUCATION

- Home Programs
- Body Mechanics
- Back School
- Gait Training

PHYSICIAN'S SIGNATURE _____

Date

Signature

*I hereby certify that the above described Rehabilitation Treatment is Medically necessary.
The Plan of Care is Established and will be reviewed every 30 days or more often as the condition warrants.*